STATE OF KANSAS
KANSAS HEALTH POLICY AUTHORITY
REQUEST FOR INFORMATION

Kansas Healthy Choices Program Summary

A. General Scope:

The Kansas Health Policy Authority (KHPA) herewith invites interested parties (IP) to respond to this Request for Information regarding the Kansas Healthy Choices program summary. Any responding IP should briefly but completely address the issues raised below, in writing, on or before January 31, 2008**.**

The responding IP will not be bound by the written response; however, because KHPA may rely upon information provided by responders when determining strategic planning, it is requested that the responding IP be as accurate as possible.

With regard to the summary provided below, the responding IP is encouraged to comment where the IP believes it appropriate to do so.

It is our intent, at a future date, to issue a Request for Proposals (RFP) and to competitively negotiate a contract for the procurement of the Kansas Healthy Choices program, as described below. This Request for Information is consistent with the program design submitted to the Centers for Medicare and Medicaid Services (CMS). The program design is a combination of the RFP and the requested State Plan Amendments (SPAs), pending final approval by CMS.

B. Overall Design of Kansas Healthy Choices:

The health and well being of residents is of utmost importance to the State of Kansas, and the creation of a family medical home is paramount to the improved health of Kansans. To support these objectives, Kansas will begin offering premium assistance to caretakers and their currently eligible HealthWave XIX children up to 100% of the Federal Poverty Level (FPL). This approach is designed to allow Kansas to ensure quality healthcare at an affordable cost for these families, promoting wellness and long-term health. This coverage, known as Kansas Healthy Choices (KHC), will focus on bringing family units into a single private health plan of their choice, empowering them to make healthy lifestyle choices and to become more active participants in their family's health and in the health care they seek and receive.

KHC Procured Plans: KHC coverage will be provided through the purchase of employer-sponsored or commercial health insurance. Both options will cover services that are actuarially equivalent to the State Employee Health Plan. The Deficit Reduction Act of 2005 amends the Social Security Act to include sections 1937 and 1938. Section 1937 allows States to provide benefit packages to Medicaid beneficiaries that differs from coverage defined in the state's approved state plan through enrollment in approved benchmark or benchmark-equivalent coverage, such as procured health plans or employer sponsored insurance plans. Section 1938 provides for 10 states to operate their Medicaid benefits to volunteer beneficiaries through a program that is comprised of a Health Opportunity Account (HOA) and High Deductible Health Plan (HDHP).

KHC Employer-Sponsored Plans: When a family determined to be eligible for Kansas Healthy Choices has access to an employer-sponsored insurance plan, an analysis will be performed to determine whether it is cost effective for the State to reimburse the family for employer sponsored coverage instead of providing services through the state-procured health plans. The family will provide detailed information about the insurance that is available to them and the Fiscal Agent will perform an evaluation based on the family's cost and the employer sponsored coverage compared to the KHC services. The State will pay the employee's portion of employer-sponsored insurance if it is less expensive than providing KHC coverage through a state-procured plan.

KHC Plan Selection Process: KHC families are determined to be eligible for a KHC procured plan will be sent a choice packet instructing eligible caretakers to select one of the statewide health plans a plan for themselves and their eligible family members. A limited number of families in two pilot counties will also be able to select the limited demonstration HOA/HDHP program. The choice packet will contain information about the type of plans, benefits and network coverage available. If a beneficiary does not choose a health plan, the family will be systematically assigned to one of the three benchmark-equivalent health plans. Assignment for KHC and their currently eligible HealthWave XIX family members begins the first of the month following the end of the required choice period. Consistent with requirements associated with receipt of Federal support for this program, neither KHC nor their currently eligible HealthWave XIX family members will be subject to waiting periods and pre-existing condition clauses that would exclude coverage for conditions as of the effective date of their coverage. Enrollment in KHC health plans will be the responsibility of the State and its fiscal agent(s).

C. Procurement of Private Health Plans:

The Kansas Health Policy Authority's (KHPA) intends to issue an RFP to select a maximum of three vendors to provide medical services on a statewide basis to KHC beneficiaries and their currently eligible HealthWave XIX family members. The contracting health care plans may subcontract for services; however, the contracting health plans shall be the sole source for the contract and will:

- Be reimbursed on a capitated per member, per month reimbursement arrangement;
- Negotiate provider reimbursement rates to meet or exceed the Medicaid fee-for-service level; and
- Provide value-added health care management and services.

When an acceptable employer-sponsored plan is unavailable, KHPA will purchase medical services from health plans for KHC beneficiaries and their currently eligible HealthWave XIX family members receiving services through the HealthWave program. These health plans will provide extended "wrap-around" coverage to this secondary population to ensure that the full Medicaid package is available to those currently receiving it. Participation in KHC will be mandatory for these groups effective January 1, 2009. Title V children will be allowed to opt in to the health care coverage, per federal and State requirements. This will allow a choice of health plans for both KHC and their currently eligible HealthWave Title XIX family members, promote unified healthcare coverage and achieve better health outcomes for the members.

Additionally, KHPA plans to pilot a demonstration program to provide health care to a smaller grouping of KHC beneficiaries and their HealthWave XIX family members through a Health Opportunity Account (HOA) and High Deductible Health Plan (HDHP) arrangement. The benefit package will remain the same as other options; however, the program will be restricted to a total of 1,000 members in one urban and one rural county only. If approved by CMS, the HOA/HDHP will serve as a fourth plan option in the pilot counties; however, beneficiaries will not be defaulted into the demonstration program. KHPA will be contracting with health plan to offer the HOA/HDHP option in two pilot counties. This health plan may be offered, but need not be offered, by one of the contractors selected to offer a statewide KHC health plan.

In selecting health plans for the procured component of Kansas Healthy Choices, consideration may focus on the following (not an exhaustive list):

- Strength of network and expected impact on the provider community. Vendors will be evaluated according to the likelihood that their provider network will meet or exceed minimum access requirements;
- Creativity and breadth of benefits offered, specifically on quality of services and wellness programs;
- Added value, choice and overall impact on beneficiaries;
- Transparency and communication with beneficiaries;
- Administrative, as well as overall cost;
- Vendor's understanding of the project;;
- Experience in providing like services;
- Qualified staff; and
- Methodology to accomplish tasks.

D. Categories of Eligibility and Expected Enrollment:

The eligibility criteria for enrollment into the benchmark-equivalent health plans include:

- Adults enrolled in the KHC medical group. These beneficiaries will be in the KHC fee-for-service system until the beneficiary has made a health plan choice or a choice has been systematically made for them. Systematic assignments of families will occur when the caretaker expresses no preference, and will be made in such as manner as to promote the continuity of a medical home.
- HealthWave Title XIX beneficiaries in the following categories of eligibility 1) children through the last day of the month of their 21st birthday; 2) persons enrolled in the Caretaker Medical group below 37% of the federal poverty level; 3) pregnant women; 4) beneficiaries currently enrolled in hospice services; and 5) beneficiaries receiving coverage under the TransMed (MA WT) or Extended Medical (MA EM) programs on December 31, 2008 until the individual has a change in coverage or a lapse in coverage at least 30 days Currently some beneficiaries qualify for these programs with higher incomes than future Healthy Choices participants. Since they will be Medicaid eligible when KHC begins, we will allow them to be "grandfathered" into the program. Future TransMed and Extended Medical participants will receive KHC benefits. These beneficiaries will be in the Title XIX fee-for-service system until the beneficiary has made a health plan choice or a choice has been systematically made for them. Children currently eligible for HealthWave XIX will be placed in the same health plan selected by their KHC caretaker. Systematic assignments of families will occur when the caretaker expresses no preference, and will be made in such as manner as to promote the continuity of a medical home.

The eligibility criteria for enrollment into the HOA plan include:

- Adults enrolled in the Kansas Healthy Choices medical group and persons who have been eligible for medical assistance for a continuous period of at least three months. These beneficiaries will be in the Kansas Healthy Choices fee-for-service system until the beneficiary has made a health plan choice.
- HealthWave Title XIX beneficiaries in the following categories of eligibility: 1) children through the last day of the month of their 21st birthday; 2) persons enrolled in the Caretaker Medical group; 3) beneficiaries currently enrolled in hospice services; 4) beneficiaries receiving coverage under the TransMed (MA WT) or Extended Medical (MA EM) programs on December 31, 2008 until the individual has a change in coverage or a lapse in coverage at least 30 days. Beneficiaries will be in the Title XIX fee-for-service system until the beneficiary has made a health plan choice or a choice has been systematically made for them. HealthWave XIX children will automatically be placed in the same health plan as the KHC caretaker.

These enrollment efforts will begin in the fall of 2008 and will, over time, move an estimated 20,000 current HealthWave Title XIX, and 24,500 newly-eligible, parents and their children into either the state procured plans, the beneficiary's employer-sponsored health plan, or the HOA/HDHP pilot. The following schedule will be used to transition the eligible beneficiaries to KHC:

January 1, 2009	Up to 50% Federal Poverty Level (FPL)
July 1, 2009	Up to 75% FPL
July 1, 2010	Up to 100% FPL

Beneficiaries will have a continuous 12-month period of eligibility assuming they continue to meet the categories of eligibility. Health care services must be available to members beginning January 1, 2009.

The following table outlines the health plan options that are available to beneficiaries participating in Kansas Healthy Choices:

Eligibility Group	Kansas Healthy Choices Options			
	Three (3) Benchmark-Equivalent Health Plans		One (1) Health Opportunity Account Plan	Employer Sponsored Insurance
	Basic Services	Wrap-around Services		
Parents up to 37% of the FPL	Yes	Yes	Yes	Yes
Beneficiaries under 21	Yes	Yes	Yes	Yes
Pregnant Women	Yes	Yes	No	Yes
Kansas Healthy Choices Adults	Yes	No	Yes	Yes

The following categories of Medicaid beneficiaries are excluded from participating in Kansas Healthy Choices:

- Beneficiaries residing in a nursing facility, nursing facility swing bed unit, nursing facility for the mentally ill, intermediate care facilities for mental retardation (ICF/MR) or head injury rehabilitation facility;
- Beneficiaries with Medicare coverage;
- Beneficiaries who have an eligibility period that is only retroactive;
- Beneficiaries enrolled in any Home and Community Based Services (HCBS) Waiver;
- Beneficiaries enrolled in another managed care health insurance plan;
- Beneficiaries eligible for SSI;
- Beneficiaries in foster care;
- Beneficiaries in the Health Insurance Premium Payment System (HIPPS);
- Beneficiaries in the State's fee-for-service lock-in program;
- Beneficiaries with a third party insurance requiring a case manager;
- Beneficiaries who reside in a State Institution; or
- MediKan beneficiaries.

E. Functions and Duties of the Contractor:

Covered services shall be available in the service area through the Contractor or their subcontractors. Health plans must comply with the Medicaid managed care regulations, as indicated in 42 CFR 438. This includes but is not limited to Early and Periodic Screening, Diagnosis and Treatment (EPSDT); children with special health care needs, cultural competency, family planning, overall service accessibility standards (such as timely access to healthcare coverage); and health notification, education and prevention.

Additionally, the health plans will work closely with KHPA to establish objectives and timetables for improvements of health care service and delivery. This includes internally monitoring the quality of care delivered by providers and subcontractors, as well as working closely with the External Quality Review Organization (EQRO). Data provided by the health plans includes information regarding providers, membership, pharmaceuticals, encounters, assignments and rural health clinic/federally qualified health center utilization data.

F. Fraud and Abuse:

The health plans must have administrative and management arrangements or procedures, and a mandatory compliance plan that are designed to guard against fraud and abuse. Contractors selected to provide one of the procured plans, and any subcontractors, shall:

- Fully cooperate with requests for information from the Kansas Medicaid Fraud Control Unit (MFCU) of the Kansas Attorney General's Office,
- Have in place internal controls, policies and procedures that are designed to prevent and detect Fraud and Abuse activities;

- Report to the State and MFCU any suspected Fraud or Abuse by KHC or HealthWave XIX provider or beneficiary within 24 hours after the Contractor or its subcontractors suspects or has reason to suspect Fraud or Abuse;
- Terminate from its KHC health plan network of providers any provider whose Title XIX HealthConnect Contract or Title XIX Provider Agreement has been terminated by the state;
- Provide member education in an attempt to correct abusive behavior; and
- Comply with other requirements of Medicaid-funded plans with respect to fraud and abuse.

G. Timely Claims Payment:

Contractors are not allowed to enter into capitated subcontracts with service providers. All provider contracts will be on a fee-for-service basis.

Timely claims payment:

- Claim means a) a bill for services b) a line item of service or c) all services for one beneficiary within a bill.
- Clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

The Contractor shall meet the following payment requirements:

- 90% of all claims including adjustments must be processed and paid or processed and denied within 30 days of receipt.
- 99% of all claims including adjustments must be processed and paid or processed and denied within 60 days of receipt.
- 100% of all claims including adjustments must be processed and paid or processed and denied with 90 days of receipt.
- Abide by the following specifications: 1) the date of receipt is the date the Contractor receives the claim, as indicated by its date stamp on the claim and 2) the date of payment is the date of the check or other form of payment.

The Contractor and its providers may, by mutual agreement, establish an alternative payment schedule. Any alternative schedule must be stipulated in the contract.

H. Medical Coverage:

The following chart provides a list of services that should be considered when creating the benefit packages for the Kansas Healthy Choices and currently eligible HealthWave Title XIX beneficiaries. Services that are mandated for either package are indicated in the appropriate columns. This includes the necessary service level that should be proposed. Health plans must propose a plan that is actuarial equivalent to the State Employee Health Plan coverage and include actuarial certification with the proposal.

Service	State Employee Health Plan Coverage	KHC Coverage Level	HealthWave XIX Coverage Level
Medical, surgical, anesthesia, diagnostic, therapeutic, and preventative services. Preventative services include: • age appropriate routine physical exams • well-woman care (office visit, PAP smear test, and STD testing)	Yes	Ear and eye exams are required to be covered at 75% of this service level. All other services at 100%	100%

Service	State Employee Health Plan Coverage	KHC Coverage Level	HealthWave XIX Coverage Level
• well-man care (office and PSA blood test) • mammogram • dietitian consultation • routine hearing exam • routine vision exam • age appropriate bone density screening • routine age appropriate colonoscopy • pediatric and adult immunizations in accordance with accepted medical practice. These services may be provided at clinics, rural health clinics, federally qualified health clinics or Indian health centers. Other services include: • diabetic supplies • blood transfusions • family planning and sterilizations • HIV testing and counseling • Screening, diagnosis and treatment of sexually transmitted diseases			
Inpatient and outpatient hospital services.	Yes	100%	100%
Laboratory services meeting Clinical Laboratory Improvement Act Standards (CLIA), as ordered by a qualified health plan provider.	Yes	100%	100%
Diagnostic and therapeutic radiology as ordered by a qualified health plan provider.	Yes	100%	100%
Emergency room services based on the prudent layperson standard	Yes	100%	100%
Mental health services, including inpatient and outpatient services, for all nervous or mental illness conditions (other than a biologically based illness).	Yes	75%	100%*
Prescription drugs, including injectable prescription drugs and intravenous drug treatments	Yes	75% Health plans are encouraged to promote the use of generic drugs; e.g., through tiered cost-sharing.	100%
Other Title XIX state plan services	Varies	Vendor's choice	100%
Other State Employee Health Benefit Plan	100%	Vendor's choice	Varies

Service	State Employee Health Plan Coverage	KHC Coverage Level	HealthWave XIX Coverage Level
Services provided by neither the Title XIX state plan or the State Employee Health Benefit Plan	No	Vendor's choice	No

*Those eligible for Medicaid Title XIX under current rules will continue to participate in the Prepaid Ambulatory and Inpatient Health Plans.

Medical necessity means that a health intervention is an otherwise covered category of service, is not specifically excluded from coverage, and is prescribed by a licensed health professional to be necessary to improve a beneficiary's health.

I. Enrollment Process:

Current enrollment procedures for KHC beneficiaries and their currently eligible HealthWave TXIX family members include the following components.

Enrollment of eligible beneficiaries not currently enrolled in a KHC health plan:

- The State's fiscal agent will send an enrollment packet to new beneficiaries. The enrollment packet will include educational materials and a toll-free number to call with questions. The enrollment packet will comply with the provisions of 42 CFR 438.10 to ensure that, before enrolling, the recipient receives the accurate oral and written information he or she needs to make an informed decision on whether to enroll. The members will have 14 days to make a choice of a health plan.
- Beneficiaries with enrollment questions may contact the fiscal agent.
- The fiscal agent will send the KHC and HealthWave XIX members a monthly eligibility card until the proposed standardized ID cards are implemented.
- At the end of the 14 day period, if the member has not chosen a health plan one will be assigned by the Fiscal Agent. When the beneficiary chooses or is assigned a health plan, the fiscal agent will send the member a letter informing them of the assigned health plan. The beneficiary is notified that he or she may make a change in the assigned health plan based on the disenrollment guidelines defined by CMS.
- After assignment, the Contractor may choose to assign new members to a Primary Care Provider (PCP). This Contractor may do this immediately, notify the member of the assignment in writing and allow the member no less than ten (10) business days to change this assignment if it is not acceptable. The Contractor may also allow all members to voluntarily choose their own PCP up-front. If the beneficiary does not choose a PCP within ten (10) business days, the Contractor shall auto-assign these members.
- After assignment, the Contractor shall send new members a welcome packet. Members will be informed that they may request, and be assigned a new PCP at any time. The welcome packet will include: PCP enrollment materials, member ID card, a member handbook, a provider listing and member's rights and responsibilities.
- At the beginning of the first month following the initial enrollment period, the Contractor shall send the member an identification card containing the benefit plan (KHC or HealthWave XIX), effective date, PCP (if applicable), Contractor organization name, how to access dental and mental health services and other relevant enrollment information. The Contractor and the State will jointly design this card.
- The Contractor will maintain a member service hotline, with specially trained operators to handle calls from new enrollees and from members needing assistance in obtaining services.
- If a primary care physician is terminated from the health plan, the Contractor shall have written policies and procedures for members to select or be assigned to a new PCP within 15 days of the termination effective date.

The Contractor shall accept, on a monthly basis, any eligible program member who selects or is assigned to the Contractor regardless of the beneficiary's age, sex, ethnicity, language needs, or health status. The Contractor shall be responsible for coverage of newborn children born to a mother assigned to the Contractor during the month of birth.

The Assignment Adjustment Process is used when a change to the existing health plan assignment occurs. The adjustment is approved and submitted by the manager of the KHC or HealthWave XIX program(s), at their discretion. When a retroactive assignment is made to the health plan, the Contractor is responsible for paying the historical fee-for-service claims even if the fee-for-service claims are past the Contractor's timely filing. When an assignment is removed from the Contractor, a recoupment of the capitation payment will occur for the appropriate months. When an assignment is added to the Contractor, a capitation payment will be made for the appropriate months. The Assignment Adjustment information is forwarded to the Fiscal Agent, Contractor and KHPA team members.

State enrollment responsibilities include the following:

- The State will conduct education and enrollment activities for program members.
- The State will make available to the Contractor on a monthly basis, an electronic roster of members enrolled in the health plan for the entire benefit month. The roster will include information consistent with the HIPAA compliant 834 transaction.
- The State will make available to the Contractor on a daily basis, an electronic roster (HIPAA 834) of members enrolled in the health plan. This roster will contain HealthWave XIX newborn children assignments and any retroactive KHC or HealthWave XIX assignment changes.
- Member choice of a health plan shall be voluntary and neither the State nor its agents shall do anything to influence the member's exercise of free choice. Members shall be provided assurances that a decision not to enroll in the Contractor's plan shall not affect their eligibility for benefits
- An application for enrollment in the program and selection of a plan, which includes a list of plans serving the members' geographic area, will be provided to the members. Staff will be available, by calling a toll-free number or in person; to assist program eligibles that request a change in health plans.
- A brochure explaining the health plan and Contractor services (such as different languages, interpreting services for the deaf, etc.) will be provided to members. Members will be advised as to which providers offer special services that the member may need. In addition, these materials will be offered in alternate formats to address physical and language barriers.
- State's responsibilities at the time of the eligibility determination will include the following:
    1) Educating the family about KHC in general, including the requirement to enroll in a single health plan, how to access services, role of the PCP (if applicable), the responsibilities of the member, their rights to file grievances, appeals, fair hearings and benefits available, in and out of the plan. The member will have a right to choose a health plan subject to the capacity of the provider.
    2) Informing the family of available health plans and outlining criteria that might be important when making a choice (e.g., presence or absence of the family's existing health care provider in a plan's network).
    3) The State will employ a method to assign to a Contractor any eligibles that do not make a voluntary selection. Assignment factors for new members may be weighted to provide equality in the number of members enrolled in the plans.
    4) Program members who are disenrolled from a health plan due to loss of eligibility will automatically be re-enrolled or assigned to the same plan should they regain eligibility within sixty (60) calendar days. The Contractor must agree to re-enroll these members. If more than sixty (60) days have elapsed, the member will be permitted to select a plan through the enrollment process. This process may change upon further design of the Kansas Healthy Choices program.
    5) The effective date of enrollment with the Contractor shall be the first day of the month in which the individual is assigned to the Contractor. The only exceptions to this are newborn members. These children are to be considered the responsibility of the contractor upon birth.
    6) Members who lose eligibility due to failure to provide eligibility reports to the State on a timely basis but whose eligibility is subsequently re-established prior

to the end of the month, will be reported to the Contractor on a second member roster sent to the Contractor on or around the fifth of each month. Capitation payments for those members reported on this second roster will be made with the regular capitation payment for the following month.

J. Marketing:

Marketing to KHC participants during the enrollment period will be limited to the enrollment process described in this program description, and as formalized in the health plan contracts. For example, the Contractor shall not influence member enrollment in the Contractor's plan through the offer of any compensation, reward or benefit to the member except for additional health-related services or informational or educational services that have been approved by the State. .

K. Payment and Funding:

Capitation rates:

- In full consideration of contract services rendered by the Contractor, KHPA agrees to pay the Contractor monthly payments based on the number of KHC and HealthWave XIX members enrolled in the Contractor.
- A separate lump-sum payment will be made to cover prenatal and delivery costs associated with the mother's medical costs for HealthWave XIX members.
- Changes to KHC or HealthWave XIX covered services mandated by Federal or state law subsequent to the signing of this contract will not affect the contract services for the term of this contract, unless (1) agreed to by mutual consent, or (2) unless the change is necessary to continue to receive federal funds or due to action of a court of law. The Contractor shall receive thirty (30) calendar days notice prior to such changes and the capitation payment shall be adjusted accordingly.
- Any rate changes of this contract will be based on legislative directives, medical costs, utilization, population trends and benefit changes in the KHC and HealthWave XIX programs.
- Payments will be reported using the HIPAA compliant 820 transaction.

Payment schedule:

- Payment to the Contractor shall be based on the Contractor enrollment data each month during the term of the contract. Payment for members assigned by a month-end (six business days prior to the last day of the month) will be made on Thursday of the first full week of each service month. Individuals who lose eligibility due to failure to provide eligibility reports to KHPA on a timely basis, but whose eligibility is subsequently re-established prior to the end of the month, will receive a full month of eligibility, and will be reported on the daily eligibility files sent to the Contractor. Payment for these members will be made with the capitation payments for the next benefit month. Contractors will be given notice if this payment schedule changes.
- Payment will be made based on the number of assignees, their eligibility category, age, gender, and geographic location.
- All payments to the Contractor for HealthWave XIX will be made for a full month and no pro-rations shall be used. The Contractor will receive capitation, retroactively, for newborns born to assigned members once eligibility has been established. The Contractor is responsible for the provision of services to the consumer for the entire time period of the capitation payment.

L. Reinsurance:

The vendor is required to provide the State with evidence of its financial ability to absorb the risk of catastrophic cases (i.e., private reinsurance coverage, or self-insurance for companies with over five years experience in Kansas). The vendor shall not expose itself to loss on any one risk or hazard to an amount exceeding ten percent (10%) of its paid-up capital and surplus unless the excess shall be reinsured in some other company duly authorized to transact similar business in this state or as otherwise provided in the insurance code. The performance bond required by the Director of Purchases should be considered separate and distinct from this provision. Stop/loss and aggregate insolvency insurance are required. Reinsurance must be approved by the State prior to Contract signing.

M. Health Opportunity Account:

The goal of the HOA program is to give participants a greater role in their own health care decision-making and to facilitate the transition to privately financed health insurance coverage. This demonstration program will be restricted to 1,000 KHC beneficiaries and their currently eligible HealthWave Title XIX family members in one urban and one rural county. This is a voluntary program and; therefore; will not receive any beneficiaries during the systematic default process.

The program design should incorporate the following:

- Create patient awareness of the high cost of medical care;
- Provide incentives to patients to seek preventive care services;
- Reduce inappropriate use of health care services;
- Enable patients to take responsibility for health outcomes;
- Provide enrollment counselors and ongoing education activities;
- Provide transactions involving HOAs to be conducted electronically and without cash; and
- Provide access to negotiated provider payment rates.

M.1 Participation

The program is available to beneficiaries that have been eligible for at least three months. Families in the demonstration counties will be offered the HOA when all family members have met this requirement. At that time, an enrollment packet will be mailed to the family and they will have 14 days to elect this program. All KHC and currently eligible HealthWave Title XIX family members will be placed into a single health plan to receive their services through the HOA program.

Enrollment is effective for up to one year. However, coverage will be terminated when:

- the family loses medical assistance eligibility;
- an individual becomes terminally ill and receives benefits for hospice care;
- an individual becomes pregnant;
- an individual reaches his/her 65th birthday;
- an individual has a break in eligibility and has not had continuous coverage for at least three months; or
- an individual meets good cause reasons as outlined 42 CFR 438.46.

Cost-sharing obligations for medical care received by the family will be deducted first from the vested portion of the HOA. If a member becomes ineligible for medical assistance, no additional contributions to the account will be made, and the account will be terminated.

M.2 Copayments and Deductibles

Family members will have an annual deductible that must be met before they can receive the medical services. Beneficiaries will be responsible for the following annual deductibles:

Adults	Up to $2,500
Child (under age 21)	Up to $1,000

The annual deductible period begins with their effective date and continues for 12 months. The full deductible amount will be made available to the family annually in the HOA when they enroll or re-enroll in the HOA program. Members will immediately vest in the HOA on a monthly basis. The monthly amount to be vested will be equal to the amount of their monthly contribution, if applicable. By CMS rules, at least 75% of the vested portion of the HOA must be available to the individual to purchase health insurance coverage after disenrollment. KHPA will work with the contractor to determine the management and uses of the vested portion of HOA accounts.

The full HOA account will be available to the family via a debit card. The family will use the debit card to satisfy all cost-sharing obligations for medical services provided for in this RFP. When the individual has met their deductible, the services will be paid for by the health plan. Nominal copayments will continue to be applied. The State will establish procedures to penalize or remove an individual from an HOA and recoup costs that derived from non-qualified withdrawals of the HOA.

M.3 Provider Payment

HOA beneficiaries must have access to the health plan's negotiated provider payment rates when paying for services that are applied to their annual deductibles. Participating provider payment rates should be consistent; regardless if the beneficiary has met the deductible. Non-participating provider payment rates cannot exceed 125 percent of the payment rate that would be applicable to services furnished by a participating provider.

Amounts in the HOA will not be used to pay providers of items and services unless the providers are licensed or otherwise authorized under State law to provide the item or service. The State will recoup payment for such a provider if the provider has been found, whether with respect to Title XIX or any other health benefit program, to have failed to meet quality standards or to have committed any acts of fraud or abuse.

In addition, the HOA will not be used to pay providers of items and services if the State finds that the items and services are not medically appropriate or necessary. The State will recoup payment for such a provider if the provider has been found to have submitted claims for such items or services.

N. Responding to this Request for Information (RFI):

1. Responding IP should include its qualifications in the response. The qualifications should provide a brief history of the IP, evidence of credibility and a resume for key staff members involved with preparation of the response to this RFI.

2. Any or all responding IPs may be requested to conduct a formal presentation to further explain and clarify the IP's understanding and approach and/or to respond to questions from KHPA in regard to the information submitted.

3. The cost of developing and submitting the information is entirely the responsibility of responding IP. This includes costs to determine the nature of this RFI, preparation of the response, submitting the response and any other costs associated with this RFI.

4. Responses should be prepared simply and economically, providing a straightforward, concise description of the information being requested in this RFI. Emphasis should be on completeness and clarity of content.

O. Pre-proposal Questions / Answers Addenda: No Pre-Proposal Q&A session will (written or otherwise) be held.

P. Pre-Proposal Conference: No Pre-Proposal Conference will be held.

Q. Response:

Please submit five (5) copies of a response to this RFI to

Kansas Division of Purchases
Proposal #10824
Closing Date:
900 SW Jackson Street, Room 102N
Topeka, KS 66612-1286

no later than 2:00 p.m. CDT on